coloration was not universal in both legs, as there were areas which retained their normal colour, though devoid of sensation. From the commencement no pulsation could be made out in either limb from the popliteal space downwards, though the femoral was pulsating freely in the groin. There was no appearance of moisture in either leg and as yet no sign of any line of demarcation. On May 28th the right leg was very painful, but discoloration was still diminishing. On May 29th the right leg began to get worse, and bullae began to appear on its outer side, over the most gangrenous area. The left leg showed no change, but now there was an area of extreme tenderness in both legs above the gangrene, but not extending in either leg above the knee-joint.

On the 30th the outer side of the left leg showed a similar large discoloured patch, without bullae.

The question of amputating both legs through the thigh was now broached, but the patient refused to hear of it and preferred to await results. During the discussion the patient mentioned having a brother at home who had gone into hospital to get a toe amputated. Gangrene of the foot followed on the amputation, and though it remained for some time eventually it cleared up. He also mentioned a sister who suffered at various times from an "internal varicose vein." On June 2nd a line of demarcation began to form on the right leg 1½ in. below head of fibula, extending downwards and inwards. This gradually encircled the leg, but there was still an excessively tender area above. Next day the bullae on the right leg broke, and for the first time an offensive smell was noticed.

On June 6th blisters began to appear on the left leg, and next day a line of demarcation began to form here also, but at a slightly lower level than on the left side. This line was completed on June 8th.

By this time his pulse time was about 120 per minute and the pulse wave was dicrotic in character. On June 11th the patient consented to a double amputation, and, though it was felt he had little chance of pulling through the double operation, it was decided to give him the slight chance there was. Accordingly it was arranged to amputate the right leg on the following day and the left leg on the day after.

Operation.—On June 12th the patient was chloroformed, and an amputation by long anterior and short posterior flaps was carried out at the junction of lower and middle thirds of the right thigh. The patient stood the operation well. There was a thrombus in the artery above the point of division, and during the operation there was very little bleeding from the flaps. An incision in the popliteal space and back of the thigh of the amputated leg revealed it to be full of foul-smelling pus.

Progress.—On June 13th the patient was very bright and was taking his food well. When the stump was dressed there was very little sign of discharge, but the area of skin over the end of the femur showed signs of commencing discoloration. The left leg was now commencing to smell.

June 14th. The patient seemed still to be improving, but he was not considered well enough to risk a second amputation.

June 15th. As the left leg was becoming very offensive, and as the patient's general condition was considerably improved, it was decided to amputate it.

Second Operation—On June 17th the amputation of the left leg was successfully performed, the patient standing the operation very well. As there was a gangrenous area of skin over end of femur in the stump of the right leg it was removed, along with a further piece of end of bone.

Progress.—Temperature, which was 102.6° F. on previous evening, dropped to normal. June 18th. Improvement continued to be marked. Both legs were dressed and found to be doing well. Slight discharge from the right leg and none from left. The patient was rather excited during dressing.

Result.—June 19th. The patient seemed well, but while his leg was being dressed he got very excited, finally lost control of himself and attempted to sit up in bed. He fell back, became very pale in the face, and commenced breathing with great rapidity. Then his breathing became very slow and his pulse began to flutter. Stimulants both hypodermically and by the mouth were freely administered, but without avail, as though he appeared to rally a bit he gradually sank and died.

Necropsy.—A necropsy was held at which the stumps were found to be both doing well, and apparently in the process of healing, The ileum showed typical healed enteric ulcers. The heart was anaemic, while the lungs only showed thrombi in the pulmonary arteries.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

THE DURATION OF MALTA FEVER.

A PATIENT of mine was invalided for "Mediterranean fever," and landed in England on the nineteenth day of the disease, which persisted until the ninety-second day, that is, seventy-three days after arrival.

It was of the intermittent type, which accounted for the supposition that, when the patient was sent away from Malta, the fever had "aborted," the temperature, which had been over 106°, falling practically to normal (98°-99°) on the tenth day.

This fall, however, was really the ending of the first "wave," the second commencing the very day of departure, and culminating with a temperature of over 104° the day after arrival, the journey lasting four days.

This second "wave" lasted twenty-one days, the temperature showing an intermediate rise each seventh day. A "wave" of low range now commenced, the morning temperature being normal, afternoon 100°, with one rise, again on the seventh day, to 101°. This third "wave" lasted eighteen days.

Next day, the fifty-third of the disease, a fourth "wave" of much higher range set in, the temperature rising to 103.5°, but usually registering between 100° and 102°. This lasted thirty-two days, the seventh day intermediate rise being again noticeable.

Three days of morning subnormal and evening normal temperature followed, when, on the eighty-eighth day of disease, the temperature again rose a degree a day, reaching 102°. This fifth "wave" only lasted five days, ending on the ninety-third day of the disease.

The temperature has now been subnormal in the morning, and normal in the evening for eighteen days. The chart—temperatures taken five times in twenty-four hours—shows beautifully the undulant character of the fever, the highest readings being between 2 and 6 p.m., and although it bears some similarity to that of remittent fever there is no question of malaria, the blood having been carefully examined and no plasmodia found. Moreover "the serum test" was applied in Malta, and the diagnosis of Mediterranean fever confirmed. Joint affections were also present.

The question of duration is of importance, as friends naturally cannot understand "why the fever lasts so long." Three to six months may, I think, be expected. Hughes gives the former period for uncomplicated cases.

In China I have seen many similar cases, distinctly not malarial (as proved by the microscope) nor typhoid, of a prolonged, undulant fever, in which so far the micrococcus melitensis has not been found, and which have not reacted to "the serum test." This may have been due to defective cultures or technique.

As to treatment, although we are told no medicines are of any use, I have certainly found salol most beneficial in the so-called typhoid stage. Having had some experience of carbolic acid in typhoid fever and plague (where it certainly seemed useful), and this also being apparently a filth disease, I tried the creolin (medical) palatinoids (Jeyes) when the fifth "wave" began, which promised to be a "high-range wave," the temperature being 101° on the second day. Whether *post hoc vel propter hoc*, it only lasted five days, as against ten, twenty-one, eighteen, and thirty-two days—the previous "wave periods." I have still continued the creolin ℳxii a day, so many "relapses" having occurred.

London. WILLIAM HARTIGAN, M.D.Brux., D.P.H.

TOXIC EFFECTS OF COLCHICUM.

ON being recently summoned hurriedly to Mr. X., aged 58, I found him with a typically "abdominal facies"—drawn, anxious, and dusky; bluish lips and nails; quick, shallow respirations; small and quick pulse, and clammy, pale skin. I knew him to be ordinarily a healthy, temperate man, though slightly gouty. He complained of intense cutting epigastric pain, of sudden onset one and a-half hour earlier, beginning with vomiting of much yellow fluid "all over the road," and several violent actions of the bowels, the motions being profuse and sanguineous. The abdomen was tender all over, the temperature 96.5°.

The clinical picture was that of a sudden serious abdominal lesion, but local indications were wanting, as was also any proof of the existence of actual involvement of the peritoneum.

Inquiry as to recent ingesta elicited that he had taken on an empty stomach some two and a-half hours before, two "Blair's gout pills," and the diagnosis seemed to lie between (1) pill poisoning, (2) ptomaine poisoning, (3) abdominal lesion, for example, perforation of appendix. The history negatived (2) and (3), but the patient's state inclined one strongly to (3). Could these two pills possibly do all this to a man? In one's painful hesitation between opposite courses of treatment, the point insisted on in an address of Sir William Broadbent's on the importance of respiratory immobility of the abdominal walls in the diagnosis of peritonitis,[1] recurred to the mind, and was of great assistance. This immobility

[1] *Clinical Journal*, October 27th, 1897, p. 3.

was absent, and I therefore diagnosed colchicum poisoning from the Blair's pills, administering appropriate treatment. Recovery followed the use of sedatives and carminatives, but not before muscular twitchings and choleraic symptoms had appeared. A month before he had taken two of these pills, with similar but much less intense symptoms. Murrell notes a case of colchicum poisoning from these pills as being recorded in the *Lancet*, vol. i, 1881, p. 368.[2] The symptoms agree generally with those of colchicum poisoning noted by Murrell and by Ewart,[3] the two chief authors accessible to me.

Intense thirst and partial vesical paralysis were also observed. The yellow vomit described by Murrell was well marked. The patient assured me that only two pills were taken, "and they would be the last two of that sort."

Pelsall, Staffordshire. L. G. DAVIES, M.D.Cantab.

STRANGULATION OF SMALL INTESTINE BY FIBROUS MESENTERIC BAND.

A NATIVE labourer, aged 20 years, was brought to the Salina Cruz Hospital on July 21st, with a history of having been ill for three days. He was groaning in agony. The temperature was subnormal, the pulse imperceptible at the wrist. The abdomen was swollen and tense, especially above the level of the umbilicus; it was tympanitic, and very tender to touch. Stercoraceous vomiting was present, and the patient's bowels had not opened for four days.

A hypodermic injection of ⅓ gr. of morph. sulph. was given to relieve his intense pain, and soap and water enemata were used, but with no good result, and the patient died four hours after admission.

The necropsy showed intense inflammation of the peritoneum. The ileum was found to be constricted by a firm fibrous band, which arose from one side of the mesentery, passed over the intestine, and was inserted into the mesentery on the opposite side. The constriction of the bowel was at a distance of about 4 ft. above the ileo-caecal valve, and did not appear to be recent, as the wall of the intestine was thickened and fibrous at this point, and the lumen was narrowed, and would only admit the passage of the forefinger. The small intestine above this point was much inflated, and filled with gas and liquid faeces, but just above the constriction there was a quantity of fibrous-looking material composed apparently of a collection of fragments of maize husks, and this had no doubt been unable to pass through the narrowed lumen, and had so been the cause of the obstruction.

There were also noted in the same case several strong fibrous cords attached by both ends to the mesentery of the ileum, and forming loops in this situation. One of these was about 6 in. in length, and another 4 in. These cords were strong, white, and fibrous, and gave one the impression that they were congenital in origin.

JOHN MCPHERSON, M.B., Ch.B.,
Port Works, Salina Cruz, Mexico.

TECHNIQUE OF VACCINATION.

THE application of a thoroughly antiseptic dressing to the vaccination wounds is no new idea. The following method I have found extremely satisfactory for the last two years. I take the opportunity of submitting it to my fellow practitioners on account of its freedom from those local inflammatory reactions and general blood infections which sometimes give considerable trouble, and cause wide-felt dread of vaccination in the public mind. I have no doubt others have used a similar dressing to their vaccinations, but to those who have not it may seem worthy of a trial. It also has the advantage of taking only a short time to perform. The skin may be cleansed and dried in the ordinary way, although this may be omitted if the arm is ordinarily clean. The vaccinations are placed in the ordinary position and performed in the ordinary way. A small round piece of green dry protective is immediately placed upon each vaccination. A collodion dressing is now applied. This consists of a thick round or oval pad of about fifty or more layers of Lister's double cyanide gauze, moistened on the under surface with 1 to 40 carbolic lotion, and sufficiently large to cover the three or four vaccinations. Over this is stretched a sheet of two layers of the gauze, the edges of which well overlap the pad. These edges are firmly gummed down with collodion. This dressing will hold on for five days, when it is removed and the vaccinations inspected. The pieces of green protective are removed and not reapplied. If they are left on the vaccinations eat very deeply into the skin. Another collodion dressing is applied, and fortified, if thought necessary, with a bandage. This dressing should be inspected in another five or six days. If any inflammatory areola is evident or discharge has come through, or it has become loosened, it is replaced by another, otherwise it is retained until the healing is complete.

During the late epidemic I performed some 100 vaccinations by this method, and had only 4 or 5 cases which became inflamed, one of which was a middle-aged, alcoholic subject, and 2 were young plethoric women. The method never fails in the susceptible. The lymph I used was Dr. Chaumier's, of which only a small amount is required on account of its potency.

Highbury, N. M. KNOX SOUTTER.

[2] *What to do in Poisoning*, ed. viii, p. 119, Colchicum.
[3] *Gout and Gouty Diseases*, p. 348.

THE TREATMENT OF VESICULAR ECZEMA.

THE variety of eczema known as vesicular commences with itching and heat in the affected parts, followed in a short time by the appearance of a crop of vesicles, which are filled with a clear fluid. These sooner or later rupture, either spontaneously or by some act of the patient, and when he comes under notice he presents one of the following appearances. The vesicles may have become confluent, and denudation of the epithelium have taken place, leaving the subjacent skin red, excoriated, and having moisture-oozing areas of greater or less size. In another type the eczematous surface is covered with crusts, which have become fissured and cracked, but exude moisture. In a third variety there are groups of discrete vesicles, with patches of healthy skin between them. These vesicles are about the size of a pin's head, and are weeping, so that although they have different appearances, these three varieties are alike in one thing—there is serous exudation constantly going on.

Various methods of treatment have been recommended, principally in the form of dusting powders or lotions, with the view of drying up the discharge; but the objection to these is that, although they do dry the oozing-up, they form cakes on the inflamed surface, and in a few days these cakes crack and fissure, and the moisture reappears between them. If the cakes are removed the skin beneath them is in a reddened and excoriated state, and the condition is really no better than at first. I have made a large number of cultivations, and in every case have found the oozing fluid swarming with staphylococci. The observations I have made show that if these staphylococci are destroyed, the moisture ceases to exude and the skin becomes at once amenable to treatment. I apply in every case of weeping eczema a solution of biniodide of mercury of the strength of 1 in 2,000 on lint, and invariably in a few days the skin becomes dry. The way is then clear to apply other remedies, as ointments or lotions, to complete the cure. Sometimes after remaining dry for a few days the oozing recommences in patches. The solution is applied by means of small pieces of lint to these patches, only leaving the rest of the inflamed skin under treatment by the other methods. The strength of the solution may be increased to 1 in 1,000, but this often causes a good deal of burning and pain; still in the cases where the 1 in 2,000 seems hardly strong enough, it may be used with advantage. In the comparatively rare cases, where the vesicles have come under notice unbroken, I have not been able always to find staphylococci, but when I have found them they have not been in such numbers as in the ruptured vesicles. The staphylococci are, of course, among the common skin bacteria, and though, in my opinion, not responsible for the outbreak, they speedily find their way into the ruptured vesicles and keep the mischief going. This method of treatment is now used in this hospital as a routine practice in every case of weeping eczema, and so far it has never failed to give a satisfactory result.

H. LYLE, M.R.C.S.Eng.,
Senior Surgeon, Liverpool Hospital for Cancer and Skin Diseases.

CASE OF INTESTINAL INFARCTION.

A SIKH, aged 22, on May 25th, 1903, at 8.15 a.m., whilst on parade was suddenly seized with intense abdominal pain somewhat colicky in character, became faint, fell to the ground, vomited, and passed a motion (normal in appearance). Previous to this he had been in good health. There was no history of syphilis or rheumatism obtainable. He was

found on examination to be in a condition of moderate collapse, complaining of great pain in the abdomen, chiefly referred to the umbilical region. The abdomen was very slightly distended and the abdominal respiratory movements were somewhat diminished. Palpation revealed no rigidity or "tumour"; there was no superficial tenderness, but deep pressure increased the pain. The abdomen was universally resonant. The pulse was rapid and weak.

Opium was given, turpentine fomentations applied to the abdomen, and food interdicted. Within two hours he again vomited, and passed another motion. He seemed better, pulse stronger, and pain less, but he was still collapsed. Later in the day, however, he became worse; the abdomen became distended and tympanitic, accompanied by more marked collapse. The temperature was subnormal. At 8 p.m. his pulse was 132, very weak and irregular. The first cardiac sound at the apex was replaced by a scarcely audible murmur, and the second sound was very weak. The patient was in great pain, lying with his legs drawn up, very restless, with anxious expression and with a cold sweat on his forehead. The tongue was moist and covered with thin white fur. His breathing was entirely thoracic.

The abdomen was generally more distended, but the epigastric and umbilical regions were rather more prominent. There was no respiratory movement whatever, no visible coils of intestine, and no gurgling audible.

The abdomen was now tender on gentle palpation. There was slight dullness in the flanks, but the patient was not turned over to see if this was movable, on account of his great pain. The liver dullness was not obliterated. The patient had passed neither flatus nor faeces since about 10 a.m. Vomiting had not recurred, though he had retched once or twice. Urine had been passed without pain.

Stimulants had been given and liq. strych. hypodermically. A soap-and-water enema, followed by one with turpentine, was given with no result. Small quantities of water only were allowed per os.

It was thought at first to be probably a case of acute intestinal strangulation, though the prolonged collapse, rapidly increasing in severity, and absence of persistent vomiting (in spite of the administration of opium not being in sufficient quantity to relieve his pain), were thought quite unusual.

As the collapse was not passing off, but steadily increasing, preparations for abdominal section were made, as although the surroundings and circumstances were most unfavourable (we were in camp and over the Border at the time), the assistance of a missionary doctor was available in a comparatively short time, and it was considered to be the only chance for the patient. In the meanwhile the patient's condition, in spite of free stimulation, became rapidly worse, and at 10 p.m. he was almost pulseless, very restless, pale with anxious expression, fully conscious, and complaining of less pain. The abdomen was still more distended. In the next hour he became steadily worse, evidently moribund, quite pulseless, with sighing respiration, and died soon after 11 p.m.

A necropsy was done about ten hours after death. On opening the abdomen by the small incision permitted sanguineous serous fluid came out in some quantity. The small ntestine which presented was found to be much distended, very congested, and deeply infiltrated with blood. On tracing it towards the caecum it was found within a few inches of the ileo-caecal junction to gradually shade off into the usual colour and consistence of the wall of the small gut. The same was found to take place on tracing the gut upwards, where within 9 in. or 10 in. of the duodeno-jejunal junction it gradually assumed a normal appearance and consistence. No obstruction whatever could be made out, and the small intestine showed no signs of constriction at any part (such as would be apparent if strangulation had produced in such a short period such severe congestion and infiltration with blood); further, the gut was withdrawn throughout with absolute freedom. On puncturing the small intestine gas and highly sanguineous thick liquid contents issued.

The superior mesenteric artery when traced up with the finger was firm and round, and the mesentery felt thickened. There was no peritonitis evident. It was remarkable that there was no diarrhoea or profuse haemorrhage from the bowels, and that the case terminated so rapidly.

H. ROTHERY NUTT, M.B.Lond., F.R.C.S.Eng., I.M.S.
Baluchistan, India.

METROPOLITAN BOROUGH COUNCIL ELECTIONS.—Mr. Bidwell, F.R.C.S., and Drs. Fletcher Little, Rotheroe, and Snape have been returned to the St. Marylebone Borough Council.

REPORTS
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

MIDDLESEX HOSPITAL.

CASE OF LYMPHATIC LEUKAEMIA.

(By OLIVER K. WILLIAMSON, M.A., M.D., B.C.Cantab., M.R.C.P.Lond.; Medical Registrar to the Hospital; Physician to Out-patients, City of London Hospital for Diseases of the Chest, Victoria Park.)

THE following case, one of lymphatic leukaemia, presenting some atypical features, is worthy of record.

History.—L. N., a married woman, aged 27, a washerwoman by trade, attended Dr. Voelcker's out-patient department at the Middlesex Hospital, and was admitted as an in-patient, under the care of Dr. Kingston Fowler, on June 12th, 1902, on account of pain in the chest and left lumbar region, cough accompanied by a sense of suffocation, slight expectoration, and wasting. Her illness had commenced gradually about three months before admission, without any assignable cause, she having first noticed loss of flesh, and after this fainting fits on exertion. For three weeks before admission she had suffered from a cough, accompanied by slight sticky, brownish expectoration, occasionally streaked with blood, also breathlessness on exertion. The cough had caused her pain over the sternum, especially its upper part, also in the right infraclavicular region, and she had also noticed tenderness over the sternum. Her appetite had been good until six days before admission: of late the bowels had been constipated. The cough had interfered with her sleep at night, and she had lost weight. She had suffered from measles when 15 months of age, and from chorea at 13 and 17 years of age. Between 1894 and 1896 she had coughed up some blood. In 1896 she had been laid up with influenza. Her father had died aged 42 years, her mother aged 50 years, both of pulmonary tuberculosis. There had been altogether eleven brothers and sisters; two sisters were living and healthy, one suffered from pulmonary tuberculosis, one had died from the same, another of bronchitis and asthma, and four from unknown causes. One brother was in an asylum, and one had died in an asylum of pulmonary tuberculosis. The mother had suffered from rheumatic fever.

State on Admission.—The patient was seen to be a rather thin woman of average height, with a full face and a pale and somewhat muddy complexion. The temperature was normal. The cervical glands on each side were markedly enlarged, there being two or three separate slightly movable portions not attached to the skin; there was also slight enlargement of the axillary glands, but no other external glandular enlargement. The chest was emphysematous in shape, the angle of Ludwig was specially prominent; expansion was greatly diminished, but equal on the two sides, vocal fremitus was diminished on the right side and absent on the left. The right side of the chest was resonant, but there was dullness extending from the right border of the sternum to about 3 in. beyond its left side. The breath sounds were exaggerated at the right apex and diminished at the left apex. Posteriorly, there was dullness at the left base and in the interscapular region, and on auscultation there were occasional crackling *râles* heard at the left base. Laryngoscopic examination revealed no abnormality. The pulse was 114, regular, small and of low tension. The cardiac impulse was in the fifth space in the nipple line, and was feeble. There was well marked systolic pulsation in the second left space, and in this space as well as at the apex a faint systolic murmur was audible. Many suppurating stumps of teeth were present, and the tonsils were enlarged. The spleen was palpable, the urine was of specific gravity 1030, containing a deposit of urates, but neither albumen nor sugar. On examination of the fundi there were found to be neither optic neuritis nor retinal haemorrhages.

Progress.—On June 19th a mixture containing liq. hydrarg. perchlor., 1 drachm, and. pot. iod., 7 gr. t.d.s., was prescribed, as it seemed not improbable that the patient was suffering from syphilis, and the signs in the chest were suggestive of aneurysm. For a few days improvement appeared to result from this treatment; she felt better, and the glands in the neck were smaller. On June 26th the iodide was increased to 15 gr. t.d.s., but on July 23rd it was noticed that the glands in the neck were harder and more fused, so that on the following day she was ordered a mixture containing liq. arsen., 3 minims t.d.s. On July 28th the patient had pain on swallowing, and the urine contained a small quantity of albumen. The liquor arsenicalis was increased to 6 minims t.d.s., and this amount was given for practically the whole of the remaining period of her first stay in hospital. On August 5th the patient felt better, and her swallowing was easier, and from this date onwards the glands became smaller and softer. On August 26th there was palpable in the left hypochondrium and left lumbar region, besides the spleen, a tumour with no notch projecting into the loin, and movable with respiration, evidently the kidney. The right kidney could not be felt. She was discharged on September 6th slightly improved.

On September 18th she was readmitted; it was then noticed that clubbing of the fingers was present, the gums were spongy, the pupils, especially the right one, dilated, the voice was weak and there was

THE GOXHILL ISOLATION HOSPITAL.

DR. THOMAS M. WATT (Goxhill) writes: Will you allow me to supply the most telling point in my letter, unfortunately omitted in your *précis*, namely, that the persistent refusal of the District Council to open the hospital promptly changed to an offer of admission upon the intervention of the Local Government Board brought about by my telegraphed appeal? This single fact practically made my case, which is incomplete without it; therefore, I ask that in fairness you will find room for it now.

UNIVERSITIES AND COLLEGES.

UNIVERSITY OF CAMBRIDGE.

Appointments.—Dr. J. N. Langley, F.R.S., has been elected Professor of Physiology in the place of Sir Michael Foster, K.C.B. Dr. A. Hill, Master of Downing, has been reappointed University Lecturer in Advanced Anatomy. Dr. A. C. Ingle has been appointed University Lecturer in Midwifery in succession to Mr. A. F. Stabb.

Research Studentship.—An Allen Studentship of £250 for one year for research in Medicine or other department of Natural Science or Moral Science will be vacant next term. It is open to graduates who are under 28 years of age. Application is to be made to the Vice-Chancellor by February 1st, 1904.

State Medicine.—The Syndicate reports that during the present year 88 candidates have presented themselves for the examination in State Medicine; 41 were successful in obtaining the diploma in Public Health.

University Studies.—A Syndicate is to be appointed to consider what changes, if any, are desirable in the studies, teaching, and examinations in the University. Among the members are Sir R. C. Jebb, Dr. D. MacAlister, Dr. Forsyth, Dr. Keynes, Professor J. J. Thomson, and Dr. W. Bateson.

UNIVERSITY OF GLASGOW.

AUTUMN GRADUATION CEREMONY.

THE autumn graduation ceremony at this University was held in the Bute Hall on November 5th. There was a crowded attendance of the public for whom the galleries and the seats in the side aisles were reserved. The area was occupied by the students, who took their usual somewhat lively share in the interesting proceedings. Principal Story presided and performed the capping ceremony. Amongst the degrees conferred were the following:

Doctors of Medicine (M.D.)—*G. M. Crawford, M.B., Ch.B. (Thesis: Nitrogen Excretion in Diphtheria); *R. N. Dunlop, M.B., Ch.B. (Thesis: An Analysis of Fifty Cases of Eclampsia; *A. Robin, M.B., Ch.B. (Thesis: A Contribution to the Haematology of Puerperal Fever, with some Observations on the Influence of the Intravenous Injection of Antistreptococcic Serum); *D. S. Sutherland, M.B., Ch.B. Thesis: An Investigation into the Specific Etiology of Scarlet Fever); *M. Watson, M.B., C.M. (Thesis: The Effect of Drainage and other Measures on the Malaria of Klang, Federated Malay States); J. Cullen, M.B., Ch.B. (Thesis: Post-scarlatinal Measles); H. C. Ferguson, M.B., Ch.B. (Thesis: On the Urinary Elimination of Chlorine in Acute Pulmonary Affections—Acute Lobar Pneumonia, Pleurisy with Effusion, and Acute Phthisis); A. Gow, M.B., Ch.B. (Thesis: A Monograph on Locomotor Ataxy, with special reference to the Disturbances of Sensation); A. W. Harrington, M.B., Ch.B. (Thesis: Broncho-pneumonia in Pertussis and Morbilli: A Study of 51 Cases); A. Mair, M.B., Ch.B. (Thesis: An Analysis of 477 Cases of Scarlet Fever; J. G. Tomkinson, M.B., Ch.B. (Thesis: Leucocytosis in Scarlatina, with a Note on Tracheotomy in this Fever); J. C. Turnbull, M.B., Ch.B. (Thesis: Infantile Hemiplegia, with Illustrative Cases).

Doctor of Science (D.Sc.).—J. Knight, M.A., B.Sc. (Thesis: Infant Foods and Infant Feeding).

Bachelors of Medicine (M.B.) and Masters in Surgery (C.M.).—J. A. Paton, W. Shedden.

Bachelors of Medicine (M.B.) and Bachelors of Surgery (Ch.B.)—W. T. Bolton, J. Craig, H. C. Davies, W. Dow, L. C. B. Head, Alice W. Maclean, J. Maclean, A. S. M'Millan, Margaret H. Smart, N. B. Stewart, Edith C. Wallace, G. H. Wildish.

* With commendation.

VICTORIA UNIVERSITY OF MANCHESTER.

Examination for D.P.H.—The Council of the University has decided that the examination for the Diploma in Public Health shall be held twice in each year, in January and in July, the next examination taking place on January 25th to 29th, 1904. Formerly the examination was held only once a year. The steady increase in the number of candidates has made this change imperative.

Representative Council.—A series of keen contests took place on November 3rd, when the undergradutes elected their representatives on the Students' Representative Council. The medical students are represented by 18 members on a total Council of 56 members.

CONJOINT BOARD IN ENGLAND.

THE following have passed the Second Examination of the Board in Anatomy and Physiology:

C. E. Anderson, King's College Hospital; B. R. Billings, London Hospital; P. Black, B.A.Camb., Cambridge University; J. Butterworth, L.D.S.Eng., Owens College, Manchester; S. E. Cathcart, Middlesex Hospital; W. H. Chesters, University College, Cardiff; S. W. Daw, Guy's Hospital; J. McD. Eckstein, St. Bartholomew's Hospital; H. R. Edwards, King's College Hospital; A. E. Evans, University College Hospital; S. H. Gandhi, Bombay and Owens College, Manchester; P. C. Garrett, Owens College, Manchester; F. W. W. Griffin, B.A.Camb., and R. A. P. Hill, B.A.Camb., Cambridge University and St. Bartholomew's Hospital; E. T. Glenny, R. L. Haines, and W. J. Jago, St. Bartholomew's Hospital; R. Jackson, University College, Liverpool; R. B. Low, University College Hospital; P. D. F. Magowan, Guy's Hospital; J. L. Meynell, London Hospital; P. Moxey, University College, Bristol; H. W. Nicholls and S. J. Rowneree, Middlesex Hospital; A. M. Pollard, King's College Hospital; J. Pugh, St. Mary's Hospital; G. A. Russell, Birmingham University; H. K. Salisbury, University College, Bristol; E. A. Saunders, King's College Hospital; E. A. Shirvell, London Hospital; G. A. Simmons, St. Thomas's Hospital; H. McL. Staley, Owens College, Manchester; J. Tate and A. C. Watkin, University College Hospital; C. Tylor, B.A.Camb., H. C. Waldo, A. C. Wilson, and W. H. Woodburn, B.A.Camb., St. Bartholomew's Hospital; I. Valerio and E. Wragg, B.A.Camb., Guy's Hospital.

MEDICAL NEWS.

DR. CHARLES J. MARTIN, F.R.S., formerly Professor of Physiology at the University of Melbourne, who was appointed Director of the Lister Institute of Preventive Medicine some months ago, has now taken up his duties. The administrative work of the Institute will in future be under his control.

LONDON SCHOOL OF TROPICAL MEDICINE.—The Craggs research prize for the best piece of original work done during the current year by present or past students of the school has been awarded to Dr. Aldo Castellani for his researches into the etiology of sleeping sickness. Dr. Travers, who also competed for the prize, has been awarded honourable mention for his paper on beri-beri.

ST. ANDREWS GRADUATES' ASSOCIATION.—At a general meeting of the Association held on November 5th it was unanimously agreed that the Association, having fulfilled the objects for which it was instituted, be dissolved, and that the balance standing to its credit be equally divided between the British Medical Benevolent Fund and the Royal Medical Benevolent College, Epsom.

PROFESSOR ARTHUR ROBINSON, Hunterian Professor, will give three lectures in the Theatre of the Royal College of Surgeons of England on November 16th, 18th, and 20th, at 5 p.m. The subject of the course will be the early stages in the development of mammalian ova and the formation of the placenta in different groups of mammals. During the present week Professor Andrew Melville Paterson has delivered a course of three lectures on the development and morphology of the sternum.

MEDICAL MAYORS.—In the list of mayors who have come into office at the commencement of the municipal year we notice the following members of the medical profession: Dr. S. J. Allden (Bridport), Dr. E. C. Andrews (Hampstead), Dr. W. Banks (Falmouth—re-elected); Dr. Frank O. Bell (Wareham), Mr. E. A. Bevers (Oxford), Dr. J. H. C. Dalton (Cambridge), Dr. E. W. Kerr (Dorchester), Dr. David Lloyd (Denbigh), Mr. J. Campbell Macaulay (Honiton)—re-elected; Mr. R. B. Searle (Dartmouth), Mr. Henry Stear (Saffron Walden—re-elected).

MEDICAL VACANCIES.

This list of vacancies is compiled from our advertisement columns, where full particulars will be found. To ensure notice in this column advertisements must be received not later than the first post on Wednesday morning.

BIRMINGHAM GENERAL HOSPITAL.—Two House-Surgeons, resident. Appointments for six months. Salary at the rate of £50 per annum.

BIRMINGHAM AND MIDLAND FREE HOSPITAL FOR SICK CHILDREN.—Two Acting Physicians.

BIRMINGHAM AND MIDLAND HOSPITAL FOR SKIN AND URINARY DISEASES.—Surgical Assistant. Honorarium at the rate of 52 guineas per annum.

CAMBERWELL PROVIDENT DISPENSARY.—Vacancy on the Medical Staff.

EAST LONDON HOSPITAL FOR SICK CHILDREN, Shadwell, E.—House-Physician, resident. Honorarium of £25 at the end of six months.

HEREFORD COUNTY AND CITY ASYLUM.—Senior Assistant Medical Officer, resident. Salary, £150 per annum.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.—(1) House-Physician, resident. Salary, £20 for six months. (2) Clinical Pathologist and Bacteriologist. Honorarium 50 guineas.

LISCARD: WALLASEY DISPENSARY AND VICTORIA CENTRAL HOSPITAL.—House-Surgeon, resident. Salary, £100 per annum.

LIVERPOOL: STANLEY HOSPITAL.—Senior House-Surgeon, resident. Salary, £100 per annum.

NEWCASTLE-ON-TYNE DISPENSARY.—Visiting Medical Assistant. Salary, £160, rising to £180, per annum.

PADDINGTON GREEN CHILDREN'S HOSPITAL, W.—(1) Surgeon to Out-patients. (2) Pathologist and Registrar. Salary, £50.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL, King William Street, W.C.—Clinical Assistants.

ST. BARTHOLOMEW'S HOSPITAL, E.C.—Surgeon.

ST. MARY'S HOSPITAL MEDICAL SCHOOL, Paddington, W.—Lecturer on Physiology. Salary, £400 per annum.

VICTORIA HOSPITAL FOR CHILDREN, Chelsea.—House-Physician, resident. Honorarium, £25 for six months.

WOLVERHAMPTON UNION.—Assistant Resident Medical Officer for the Workhouse. Salary, £130 per annum.

WREXHAM INFIRMARY.—Resident House-Surgeon. Salary, £80 per annum.

MEDICAL APPOINTMENTS.

BACQUE, W. J., M.R.C.S.Eng., L.R.C.P.Lond., District Medical Officer of the Bath Union.

BAILEY, Robert Cozens, M.S.Lond., F.R.C.S., Assistant Surgeon to St. Bartholomew's Hospital.

BENT, Sidney C. H., M.D.Brux., M.R.C.S., L.R.C.P.Lond., Senior House-Surgeon to the Evelina Hospital for Sick Children, Southwark.

BLACKHAM, Robert J., L.R.C.P.E., Captain R.A.M.C., Clinical Assistant in the London School of Gynaecology, the Hospital for Women, Soho Square, W.

BOURNE, Eleanor E., M.B., Ch.M.Syd., Resident Medical Officer to the Brisbane General Hospital, *vice* Dr. Fearnley, resigned.

Browne, J. J., M.R.C.S., L.R.C.P., Certifying Factory Surgeon for the Wigton District, Cumberland.

De Lisle, Frederick Irving, L.R.C.P.Edin., L.S.A., D.P.H., District Medical Officer, Wellington, New Zealand.

Duncan, William Henry, L.R.C.P. & L.R.C.S.Edin., House-Surgeon to Nottingham Children's Hospital.

Ede, A. G., M.B.Lond., District Medical Officer of the Ongar Union.

Fairfax, E. W., M.B., Ch.M.Syd., M.R.C.S.Eng., Honorary Anaesthetist to the University Dental Hospital, Sydney, N.S.W.

Farncombe, W. T., M.D.Brux., M.R.C.S., L.R.C.P.Lond., Certifying Factory Surgeon for the Selly Oak District, Worcestershire.

Greenwood, Alfred, M.D., D.P.H., Medical Officer to the Blackburn Education Authority.

Heslop, A. H., M.B., B.S.Durh., Second Assistant Medical Officer of the City Asylum, Gosforth.

Lyons, Alexander, M.R.C.P., L.R.C.S.Edin., House-Surgeon to the Royal Eye Hospital, Southwark, *vice* Thos. E. Frazer-Toovey, F.R.C.S.Edin., resigned.

Parsons, E. D., M.R.C.S., L.R.C.P.Lond., House-Physician to the Evelina Hospital for Sick Children, Southwark.

Penberthy, W., M.R.C.S., L.R.C.P.Lond., Certifying Factory Surgeon for the Wivelscombe District, Somerset.

Stuart-Low, William, F.R.C.S.Eng., Assistant-Surgeon to the Central Throat and Ear Hospital, Gray's Inn Road.

Symes, W. J., M.B., B.S.Durh., Medical Officer and Public Vaccinator for the Chesterfield District of the Chesterfield Union, *vice* F. Edmunds, M.R.C.S., L.R.C.P., resigned.

Thomas, Charles E., M.R.C.S.Eng., L.S.A., Port Health Officer for the Port of Timaru, New Zealand, *vice* Dr. Reid, resigned.

Wheeler, E. R., M.R.C.S., L.R.C.P.Lond., Assistant House-Surgeon to the Evelina Hospital for Sick Children, Southwark.

Whitelocke, R. H. Anglin, M.D., M.Ch.Edin., F.R.C.S.Eng., Lichfield Lecturer in Clinical Surgery in the University of Oxford.

DIARY FOR NEXT WEEK.

TUESDAY.

Pathological Society of London, King's College, W.C., 8.30 p.m.—Mr. G. L. Cheatle: The Behaviour of Cancer in Nerve or Trophic Areas. Professor E. T. Hewlett: The Agglutination Reaction in Tropical and Asylums Dysentery; and other communications.

Chelsea Clinical Society, Chelsea Dispensary, Manor Street, Chelsea, S.W., 8.30 p.m.—Dr. G. Eric Pritchard: The Inheritance of Acquired Characteristics. Dr T. B. Hyslop: The Examination of a Person Alleged to be Insane. Dr. C. C. Gibbes: Cases.

THURSDAY.

Harveian Society of London, Stafford Rooms, Titchborne Street, Edgware Road, W., 8.30 p.m.—D. B. Lees: The Treatment of Some Acute Visceral Inflammation. (Third Harveian Lecture.)

Ophthalmological Society of the United Kingdom, 11, Chandos Street, Cavendish Square, W., 8 p.m.—Cases. 8.30 p.m.—Papers: Mr. E. Nettleship, Indirect Gunshot Injury of the Eye. Major Maynard and Dr. Leonard Rogers: Pulsating Exophthalmos accompanying Internal Hydrocephalus. Dr. Freeland Fergus: (1) An Easy Operation for Ectropion; (2) Average Visual Acuteness. Mr. N. B. Harman: The Judgement of the Size and Distance of Objects. Dr. Gordon Byers: Catarrhal Inflammation of the Lachrymal Apparatus.

FRIDAY.

Society for the Study of Disease in Children, 11, Chandos Street, Cavendish Square, W., 5.30 p.m.—Cases and specimens by various members. Papers: Mr. A. Carless, Lymphangiomata; Mr. T. Clinton Dent, Pyloroplasty for Hypertrophic Stenosis; Dr. E. Cautley, Hypertrophic Stenosis of the Pylorus.

Epidemiological Society, 11, Chandos Street, Cavendish Square, W., 8.30 p.m.—Professor W. J. Simpson: Some Remarks on the Epidemiology of Plague.

POST-GRADUATE COURSES AND LECTURES.

Charing Cross Hospital, Thursday, 4 p.m.—Demonstration of Medical Cases.

Hospital for Consumption and Diseases of the Chest, Brompton, Wednesday, 4 p.m.—Lecture on Thoracic Aneurysm.

Hospital for Sick Children, Great Ormond Street, W.C., Thursday, 4 p.m.—Lecture on Diabetes in Children.

Medical Graduates' College and Polyclinic, 22, Chenies Street, W.C.—Demonstrations will be given at 4 p.m. as follows: Monday, Skin; Tuesday, Medical; Wednesday, Surgical; Thursday, Surgical; Friday, Throat. Lectures will also be given at 5.15 p.m. as follows: Monday, The Present Position of Experimental Inquiry in Relation to Cancer; Tuesday, How to Treat a Case of Insanity; Wednesday, On the Operative Treatment of Piles and Kindred Affections; Thursday, Intestinal Obstruction Friday, Some Points in Climatic and Balneary Therapeutics.

Mount Vernon Hospital for Consumption and Diseases of the Chest, 7, Fitzroy Square, W., Thursday, 5 p.m.—Arrested Pulmonary Tuberculosis, especially in regard to Treatment.

National Hospital for the Paralysed and Epileptic, Queen Square, W.C.—Lectures will be delivered at 3.30 p.m. as follows: Tuesday, Diseases of the Cerebellum; Friday, Optic Neuritis.

North East London Post-Graduate College, Tottenham Hospital, N., Thursday, 4.30 p.m.—Surgical Diseases of Children.

Post-Graduate College, West London Hospital, Hammersmith Road, W.—Lectures will be delivered at 5 p.m. as follows: Monday, Malignant Disease of the Uterus; Tuesday, Practical Medicine; Wednesday, Pelvic Pain; Thursday, Urinary Cases; Friday, Slaughterhouses.

Samaritan Free Hospital for Women, Marylebone Road, N.W., Thursday, 3 p.m.—Lecture on Uterine Tumours.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcements of Births, Marriages, and Deaths is 3s. 6d., which sum should be forwarded in post-office orders or stamps with the notice not later than Wednesday morning, in order to ensure insertion in the current issue.

BIRTHS.

Dyson.—On November 5th, at 25, Aldersgate Street, E.C., the wife of Malcolm G. Dyson, F.R.C.S., of a son.

Gairdner.—At Cairo, on the 8th inst., the wife of the Rev. William Henry Temple Gairdner, B.A., a son.

MARRIAGE.

Muller—McKeand.—On November 5th, at Airlies, Whanthill, Wigtownshire, by the Rev. Campbell-Taylor, M.A., Charles Herold Muller, M.B.Edin., second son of Rev. Professor Muller, of Stellenbosch, Cape Colony, to Isabel Nivison McKeand, M.B.Edin., eldest daughter of Peter McKeand, J.P., of Airlies.

DEATHS.

Cradock.—On Sunday, November 1st, at her residence, 52, Huskisson Street, Liverpool, Lucy Elizabeth Cradock, L.R.C.P.I.

Jones.—On November 4th, at the residence of his father, Talbot Road, Wrexham, George Kimball Jones, of Derngate, Northampton, M.R.C.S. & L.R.C.P.Lond.

Lawton.—On October 31st, at Poole, aged 52 years, Herbert Alfred Lawton, M.D.Durh., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A., M., and D.P.H., late Medical Officer of Health.

LETTERS, NOTES, AND ANSWERS TO CORRESPONDENTS.

Communications respecting Editorial matters should be addressed to the **Editor, 2, Agar Street, Strand, W.C., London**; those concerning business matters, advertisements, non-delivery of the **Journal**, etc., should be addressed to the Manager, at the Office, 429, Strand, W.C., London.

Original Articles and Letters *forwarded for publication are understood to be offered to the* British Medical Journal *alone, unless the contrary be stated.*

Authors desiring reprints of their articles published in the British Medical Journal are requested to communicate with the Manager, 429, Strand, W.C., on receipt of proof.

Correspondents who wish notice to be taken of their communications should authenticate them with their names—of course not necessarily for publication.

Correspondents not answered are requested to look at the Notices to Correspondents of the following week.

Manuscripts forwarded to the Office of this Journal cannot under any circumstances be returned.

In order to avoid delay, it is particularly requested that ALL letters on the editorial business of the Journal be addressed to the Editor at the Office of the Journal, and not at his private house.

Telegraphic Address.—The telegraphic address of the EDITOR of the **British Medical Journal** is *Aetiology, London.* The telegraphic address of the **MANAGER** of the **British Medical Journal** is *Articulate. London.*

☞ *Queries, answers, and communications relating to subjects to which special departments of the* British Medical Journal *are devoted will be found under their respective headings.*

QUERIES.

Pruritus Vulvae.

Scotus asks for suggestions in the treatment of a case of pruritus vulvae in a married woman, aged 38. Beyond a slight varicosity of the veins there is no morbid condition visible, but there is some mucoid discharge. Neither hot douche nor any external application seems to have much effect on the condition, but the trouble disappears entirely during the menstrual flow, only to come back when it is over. The urine is rather acid.

Operative Treatment of Ascites in Cirrhosis.

Dr. G. A. Leon (Sidmouth) writes: Referring to the letter of Dr. Hale White and Dr. H. C. Thomson under the above heading in the British Medical Journal of October 31st, it would be useful to know what are the signs of early chronic peritonitis to which they allude. The references which they give to the *Guy's Hospital Reports* and the *Transactions* of the Royal Medical and Chirurgical Society are not of easy access to all of us. Take for instance the following case in my practice: "Mrs. C., aged 38, first complained of pain in the right side September, 1896. Seen by me in July, 1897, in consultation with Dr. Davy, of Exeter. Hypertrophic cirrhosis and ascites then diagnosed; no thickening of omentum then noticed. No history of syphilis, but has taken alcohol in moderate quantities. Gave antisyphilitic treatment for two months without benefit. Tapped her many times between August, 1897, and December, 1901. Altogether 710 pints of fluid drawn off between those dates. In November, 1898, I note that the liver has shrunk, that the omentum is much thickened and enlarged vessels can be clearly felt through the abdominal wall. Since December, 1901, she has not been tapped. All through her illness, with few exceptions, she has been getting about and doing her housework as a tradesman's wife. She is still in fair health, at work all day, and has not needed a doctor for over eighteen months." Now, Sir, my question is, how could the clinical diagnosis of chronic peritonitis be formed at the commencement of such a case as the above? I was recommended, certainly by two consulting surgeons, to submit Mrs. C. to an operation, but as she was doing well I did not think it advisable. In November, 1898, there was no doubt chronic peritonitis, possibly set up, and probably accelerated by the frequent perforations with a trocar; and most likely it was owing to the consequent adhesions that a collateral circulation was established. Theoretically cases which evidence chronic peritonitis are precisely those cases which should improve without operation. I think an important part of the treatment of these cases is to allow the patient to get about whenever possible.

ANSWERS.

W. R. P. would do well to recommend to his lay friend a good textbook on hygiene. Perhaps for non-medical readers Newsholme's *Hygiene*, 4s. 6d. (Gill and Sons) would best meet the requirements. If general information on legal matters is required, the special chapters on Law in Reid's *Practical Sanitation* or in Parkes's or Whitelegge's *Hygiene* should be consulted. It is very useful for the members of a local authority to take in a journal dealing with sanitation—for example, *Public Health*.

Military Officer's Debts.

A Correspondent wants to know how to enforce a claim for professional services against an officer on the active list who may be serving abroad or at home. This is a very comprehensive question, involving complicated details. We would first presume that the debts of a commissioned officer on the active list cannot be treated differently from those of a civilian, and are recoverable similarly. If so, the first element is locality and jurisdiction; in England or Ireland the county court, in Scotland the sheriff court, in debts under £50. The next is, if the debt be disputed it must go to trial. The courts have means of enforcing their decision by arrestment, attachment, or execution. As to recovery from officers serving abroad, we presume the debtor should be sued civilly and locally where serving—a difficult business. We have often heard of appeals to the Commander-in-Chief or Secretary of State for War regarding absent officer's debts; but we much doubt if these officials could or would take action. Under any circumstance our correspondent should consult a solicitor.

NOTES, LETTERS, Etc.

Introductory Lectures.

A. G. P. writes: Dr. William Osler, in his address to the students of Toronto University, expresses a doubt as to the value of the introductory lecture. I think there are few members of the medical profession